health reform MINNESOTA
A Better State of Health

Workforce Work Group Priority Recommendations to the Governor's Health Care Reform Taskforce

	Recommendation	Sector	Actions/Resources
1	Remove practice barriers for advanced practice nurses by adopting the Advanced Practice Registered Nursing (APRN) Consensus Model and enacting the APRN Model Act and Rules.	Primary Care	Legislation
2	Increase availability of mental health and substance abuse services through investments in the Mental Health Substance Abuse Workforce	Mental Health and Substance Abuse	Public – private partnership
3	Increase the supply of primary care workforce and stabilize support for all health professions education by supporting existing health professions training sites and targeting new sites for primary care physicians, APRNs, physician assistants and pharmacists. Fund these efforts by restoring the 2011 cuts in funding and providing additional funds to the Medical Education and Research Costs (MERC) program.	Primary Care	Legislation Budget request
4	Increase the supply and improve the stability of the long term care workforce by increasing wages and benefits of direct care workers employed in nursing homes, in-home care, etc., as compared to counterparts working hospitals, ability to do some targeted career advancement	Long Term Care	Legislation Budget request
5	Improve access to care in Greater Minnesota by supporting and expanding telehealth and related technology to improve quality and access and extend workforce capacity.	Telehealth	Legislation and possible budget request Coordination with Governors' BBTF
6	Improve access to dental care by supporting start-up changes and practice redesign for dental therapists and advanced dental therapists; and support all state-level administrative actions to enable dental hygienists with a collaborative agreement with a dentist to perform oral examinations as part of child and teen checkups.	Oral Health	Budget request DHS Administrative action
7	Increase the number of health professionals in underserved areas by restoring and increasing the state's Health Professional Loan Forgiveness Program beyond its pre-cut 2011 budget and opening the program to additional groups of health professionals.	Primary Care	Legislation Budget request
8	Increase the supply of long term care workers by expanding the Minnesota FastTRAC (Training, Resources, and Credentialing) program that trains nontraditional adult learners	Long Term Care	Budget request
9	Increase diversity in the healthcare workforce by supporting a range of health professions diversity programs and helping foreign-certified physicians obtain Minnesota licensure and investing in recruiting diverse medical school candidates	Healthcare Workforce Diversity and Pipeline	Budget request
10	Consider the impact of MN joining the Interstate Nurse Licensure Compact, through establishing a stakeholder work group and conducting a study of relevant issues.	Primary Care	Budget request and related legislation

Workforce Work Group Priority Recommendations

Recommendation 1: Remove practice barriers for advanced practice nurses by adopting the Advanced Practice Registered Nursing (APRN) Consensus Model and enacting the APRN Model Act and Rules.

Sector: Transform Primary Care

Explanation: This strategy removes scope of practice barriers to APRN practice such as the statutory requirement for collaborative management and prescriptive agreements with physicians. It enables APRNs to practice to the full extent of their education and training. There are 5,532 APRNs in Minnesota and four APRN certification categories: Nurse Practitioner (CNP); Registered Nurse Anesthetist (CRNA); Clinical Nurse Specialist (CNS); Nurse Midwife (CNM). APRNs hold graduate/post-graduate degrees from accredited institutions. National certification assures the public that APRNs are prepared to practice in the advance role because they have achieved the required education and have passed a psychometrically sound examination that measures competency. APRNs meet the HRSA definition of "mental health professional" and enhancing their role would help address the severe shortage of psychiatrists in Minnesota, especially in non-metro areas.

Statement of Problem Addressed by Recommendation; Rationale and Data to Explain why Recommendation is a Priority:
Abundant research evidence demonstrates the critical role advanced practice registered nurses (APRNs) play in increasing the primary care workforce; providing safe, effective, quality care and effective chronic disease management; and in transforming our health care system to optimize health promotion and prevention. Currently, APRNs are not allowed to practice to the fullest extent of their education and training because of statutory barriers in Minnesota's Nurse Practice Act (the Act). The Act mandates APRN practice must occur in settings that provide for a collaborative arrangement between an APRN and a physician in order to care for and manage patients, and limits prescriptive authority to those APRNs who maintain a signed written prescriptive agreement with a physician. In contrast, 17 states and the District of Columbia (AL, AZ, CO, DC, HI, IA, ID, MT, ND, NH, NM, OR, RI, UT, VT, WA, and WY) allow APRNs to diagnose, treat and manage patients and prescribe medications and devices without requirements for physician collaboration or supervision.

The Consensus Model for APRN Regulation establishes national standards for uniform regulation of APRNs in all states. The Consensus Model was developed by 48 APRN nursing organizations. The basic requirements for every APRN include the following:
f Graduate education for all nurses wishing to practice as an APRN;
f Certification by a national nursing certification body;
f Licensure by a state board of nursing;
f Regulation by a state board of nursing;
f Use of the APRN title followed by the specific role the APRN is authorized to practice (CNP, CNS, CRNA, or CNM); and
f National accreditation of all APRN programs by an accrediting organization that is recognized by the U.S. Department of Education and/or the Council for Higher Education Accreditation.

Examples of how statutory barriers limit consumer access to care include:

- APRNs cannot establish and operate nurse-managed health clinics in Minnesota because of the requirement to employ one or more physicians. Evidence from such clinics in other states demonstrates increased access to care and improved healthcare outcomes to vulnerable populations including those who are uninsured or under-insured.

- Psychiatric-mental health (PMH) CNSs or NPs effectively counsel and provide medication management for people experiencing mental health problems; however, many have had difficulty partnering with a physician willing to sign their prescriptive agreements, especially in rural areas. PMH-CNSs and NPs have provided competent and much needed mental health services for over 30 years. When the physician with whom an APRN has had a prescribing agreement leaves the area, the APRN is unable to continue to provide care to patients.
- APRNs living in rural areas with inadequate physician coverage are unable to open primary care practices to serve the population unless they can find a physician willing to enter into some type of collaborative practice arrangement and sign the APRNs' prescriptive agreements.

The current statutory restrictions applied to APRNs pose barriers to Minnesota citizens' access to safe, affordable health care. Moreover, these restrictions limit cost-savings that could be realized by increasing APRNs' capacity to provide care.

Who would implement the recommended strategy: MN Board of Nursing

Implementation Resources Needed: legislation to amend the Nurse Practice Act

Intended Outcomes, if implemented (on health care, health status, access and/or cost, including return on investment, if available): This strategy will impact approximately 5,532 APRNs currently practicing in Minnesota. Removing practice barriers will alleviate shortages and increase access, especially to primary care and mental health services. It will encourage fuller utilization of APRN resources, and consequently increased efficiency and cost effectiveness. Comparable results in areas of health status, satisfaction, and use of specialists.

Anticipated Implementation Challenges: Scope of practice proposals can be controversial

Sources:

AARP & RWJF Center to Champion Nursing in America (2011). *Practice and access to care.*

APRN Consensus Work Group and National Council of State Boards of Nursing APRN Advisory Committee (2008). *Consensus Model for APRN Regulation: Licensure, Accreditation, Certification &Education.*

Dulisse, B., & Cromwell, J. (2010). No harm found when nurse anesthetists work without supervision by physicians. *Health Affairs, 29,* 1469-1475. doi: 10.1377/hlthaff.2008.0966

Hansen-Turton, T. (2005). The nurse-managed health center safety net: a Policy solution to reducing health disparities. *Nursing Clinics of North America*, 40, 729-738.

Institute of Medicine (2010). *The report on the future of nursing: Leading change, advancing health.* Washington, D.C.: National Academy Press.

National Council of State Boards of Nursing (2008). *APRN Model Act & Rules.*

Newhouse, R.P., et al. (2011). Advanced practice nurse outcomes 1990-2008: A systematic review. *Nursing Economics, 29*(5).

Primary Care Workforce Steering Committee of the Governor's Workforce Development Council (2011). *Minnesota's primary care provider shortage: Strategies to grow the primary care workforce.*

Recommendation 2: **Increase availability of mental health and substance abuse workforce through education and training grants to higher education institutions and mental health employers, and foster mental health and substance abuse competencies among other healthcare professionals for timely screening and successful identification of such disorders.**

Sector: Investments in the Mental Health and Substance Abuse Workforces

Statement of Problem Addressed by Recommendation: State and national trends also suggest that the emerging medical and behavioral workforces are not prepared to deliver services in the current healthcare environment. This is due, in part, to dramatic changes in the behavioral healthcare field and the difficulty of academic training programs to keep pace with these changes. There is a gap between what is actually being taught in those programs, and the knowledge and skills that are necessary to work effectively in the increasingly integrated primary care and behavioral health settings that are emerging in the context of health reform. Approximately 70% of mental health and substance abuse conditions are treated by primary care physicians, yet physician training to screen for, identify, treat and/or make referrals for mental health and substance abuse treatment is inconsistent (Better for family medicine and limited for pediatrics, internal medicine and OB/Gyn). Interdisciplinary training occurs in some settings, but both mental health professionals and physicians need training about how to work in a team model. This must be part of workforce education. DIAMOND has provided excellent experience and models for primary care, psychiatric and mental health professional team work..

Within the mental health and substance abuse fields, shortages exist in many disciplines. Psychiatrists are in very short supply, especially in rural and greater Minnesota, and the number of child and adolescent psychiatrists is extremely low throughout the state. Psychologists are more available across Minnesota as compared with psychiatry; however, rural counties in Minnesota continue to have sparse coverage, with ten counties having no psychologists. Almost of psychologists located in the five county metro area. The Bureau of Health Professions predicts that demand for general psychiatry services will increase nearly 20% between 1995 and 2020, and demand for child and adolescent psychiatric services will increase 100% during that same time. Unlike the mental health field, most substance abuse treatment providers enter the field later in life, and high tuition costs and low pay for the addiction treatment field are often cited as major barriers to entering the field.

Educational grants and training is needed to develop a workforce that is prepared to deliver mental health and substance abuse care in an inter-professional setting. Both mental health and substance use disorder training programs could be improved with expanded cross-training of professionals in the areas of co-occurring disorders and longitudinal health care for sustained long-term recovery. For example, Minnesota recently passed legislation to develop a certification process for providers seeking to offer integrated diagnosis and treatment of both mental health and substance abuse disorders (IDDT Certification). There is also a need for behavioral health specialists to develop basic competencies in the assessment and treatment of both mental health and substance abuse disorders. Finally, there are similar needs among other health care providers such as pediatricians and long-term care providers to ensure that these workers receive substantive orientation or training about behavioral health problems and their treatment.

Rationale and Data to Explain why Recommendation is a Priority: The move towards new models of integrated care and financial incentives to achieve better outcomes and improved wellness for the patient being treated in <u>any</u> health care setting requires that new professionals and paraprofessionals entering these fields have the broadest training possible to enhance their value in these new models of care. Increased training for primary care providers to assist in identifying and managing mental illness or drug and alcohol misuse/dependency (in addition to serious psychiatric issues and severe long-term substance use disorders that are often easier to identify) are important in bridging the gaps in behavioral health workforce needs. For pediatricians, being able to identify developmental delays and mental health symptoms at the earliest time – including infant and toddler check-ups – and being comfortable discussing findings and behavioral health

treatment options, is also needed. Enhancing basic primary care knowledge among behavioral health workers and long-term care workers is also necessary to identify and address preventative and treatable medical conditions such as diabetes, hypertension, obesity and asthma.

In 2012, the Minnesota Department of Human Services began development of a Minnesota Center of Excellence for Evidence-Based Practices in Mental Health. The Center will be housed at the University of Minnesota Continuing Education Department and is expected to be functional as a training center in 2013. Continuing education grants will increase current workforce capacity in evidence-based treatment through a certificate offered by the Center of Excellence. One certificate that will be offered is the Integrated Dual Disorder Treatment (IDDT) certificate. This certificate allows mental health and substance treatment professionals a designation of competency to treat individuals with the dual disorder of mental illness and substance use. In 2013, the state will implement provider standards in IDDT and providers will be certified in IDDT. Students receiving an IDDT certificate will be able to seek employment at certified IDDT provider sites. Although the Patient Protection and Affordable Care Act created a federal grant program to further this aim, it was never funded and it remains unclear if Congress will appropriate funds for it. The State could create its own state grant to invest in an educated and interdisciplinary work force.

Implementation Resources Needed:

A. Create and fund continuing education grants targeted at the current workforce employed by mental health and substance abuse treatment providers. These grants would be awarded to eligible employersto support investments in the current workforce by funding competency-based training in evidence-based practices. While research has demonstrated best treatment practices for several years now, educational institutions have not incorporated these practices into curriculum, nor as continuing education credits leading to a certification. The estimated training costs for current professionals to achieve Integrated Dual Disorder Treatment certification is about $1,400 per person. (Training 500 professionals = $700,000.)

B. Fund expansion of training on screening, brief intervention, referral/treatment (SBIRT) of substance use disorder to primary care clinicians, emergency department staff and mental health professionals not already covered by Minnesota Health Plan contractual agreements with DHS. (Cost estimated at $300,000.)

C. Create and fund ($2million) mental health and substance abuse education and training grants modeled after the Section 756 of the Affordable Care Act, and award grants to eligible higher education institutions to recruit and educate students in--

   (1) baccalaureate, master's, and doctoral degree programs of social work;

   (2) accredited master's, doctoral, internship, and post-doctoral residency programs of psychology for the development and implementation of interdisciplinary training of psychology graduate students for providing behavioral and mental health services, including substance abuse prevention and treatment services;

   (3) programs/ internships in child and adolescent mental health in psychiatry, psychology, school psychology, behavioral pediatrics, psychiatric nursing, social work, school social work, substance abuse prevention and treatment, marriage and family therapy, school counseling, or professional counseling;

   (4) state-licensed mental health nonprofit and for-profit organizations to enable such organizations to pay for programs for pre-service or in-service training of paraprofessional child and adolescent mental health workers.

(5) effective verbal and non-verbal de-escalation skills as part of mental health crises response teams to minimize trauma and stigmatization to patients, and prevent injuries to both responders and patients.

b. Funding : $3 million per year (total) in state appropriations requested.

c. Public-private partnership - Regardless of whether state creates this grant fund, there is still a need for change within educational systems by working with the educational institutions that train individual practitioners, and oversight organizations that accredit, certify, and license training and service programs.

Intended Outcomes, if implemented (on health care, health status, access and/or cost, including return on investment, if available):

Increase in the supply of trained mental and behavioral health, and substance abuse professionals leading to better access to treatment for mental and addictive disorders. Increase in interdisciplinary training in mental and behavioral health, and substance abuse issues for other health care professionals leading to better care coordination and care delivery in a patient-centered setting.

Recommendation 3: Increase the supply of primary care workforce and stabilize support for all health professions education by supporting existing health professions training sites and targeting new sites for primary care physicians, advanced practice registered nurses, physician assistants and pharmacists. Fund these efforts by restoring the 2011 cuts in funding and providing additional funds to the Medical Education and Research Costs (MERC) program.

Sector: Transform Primary Care

Statement of Problem Addressed by Recommendation: Communities depend on sufficient numbers of health professionals to provide care for their populations in both primary care and specialty practices. While many factors affect population health, the presence of sufficient numbers of providers is a key ingredient of the care system. Reimbursement is not sufficient for training institutions to cover the costs of clinical training, and Minnesota has funded clinical health professions training through the MERC program since 1996.

The MERC budget was halved in 2011 and will be only partially restored in 2012. The pool of MERC funds must support both primary care and specialty training. In addition, current federal Medicaid restrictions require funds be distributed entirely on the basis of each training site's Medicaid revenue, regardless of the number of trainees, site training costs or any consideration of state priorities. This makes it impossible to target MERC to primary care sites.

Rationale and Data to Explain why Recommendation is a Priority: Workforce needs tie directly to the health care delivery system, and MERC is the state's foundation investment in Minnesota's system of clinical training. Restoring MERC will greatly stabilize health professions training in Minnesota, and investing new resources specifically in new primary care training capacity will support the redesign of practice to the team-based, primary-care centered approach needed to achieve health reform goals and transform primary care.

J Gen Intern Med. 2002 April; 17(4): 283–292. Medicare Financing of Graduate Medical Education Intractable Problems, Elusive Solutions Eugene C Rich, MD, Mark Liebow, MD, Malathi Srinivasan, MD, David Parish, MD, James O Wolliscroft, MD, Oliver Fein, MD, and Robert Blaser

Perry A. Pugno, William Ross Gillanders, and Stanley M. Kozakowski (2010) The Direct, Indirect, and Intangible Benefits of Graduate Medical Education Programs to Their Sponsoring Institutions and Communities. Journal of Graduate Medical Education: June 2010, Vol. 2, No. 2, pp. 154-159.

Medical Education and Research Cost (MERC) 2011 Report to the Legislature. MDH, St. Paul

Who would implement the recommended strategy (state agency, health plans, etc.)

MDH, DHS

- Restore MERC formula grants to 2011 levels, with the existing formula. Cost: $14.4 million/year.
- Encourage CMS to allow formula revisions to re-associate some portion of MERC funding with training costs and activity.
- Fund a new state only MERC pool for primary care[1] training of 150 physicians, advanced practice nurses, physician assistants and pharmacists. Costs to subsidize 50% of the costs of new slots for students/residents in these areas are approximately $7.1 million/year, including 1 FTE for administration and for workforce analysis/planning. Expansion funds could be targeted to teaching programs that implement standards/competencies/outcomes for residents and students such as care coordination, team-based care, shared decision-making, etc. Higher subsidy could be provided for new slots in underserved or shortage areas.

Intended Outcomes, if implemented: (on health care, health status, access and/or cost, including return on investment, if available)

Health professions clinical training provides significant benefits to patients' health, to care systems, and to communities. Residents and other students provide service while learning, and may care for low income patients, provide emergency care and cover after-hours care. Training in high need settings increases the likelihood of providing care in underserved regions after graduation.

In recent years, MERC has supported the clinical education of approximately 3,000 health professions students. This proposal would restore support to pre-2011 levels and add support for the training of 150 – 200 primary care providers. Most Minnesota-educated health professionals remain in Minnesota to practice.

In addition to the public benefit derived from supplying competent health providers, teaching hospitals and academic medical centers help maintain the health care safety net by serving as the providers of care for much of the safety net population. The medical innovation and scientific/technological advancement occurring in GME settings are another critical public good accruing to all society. GME programs also have a positive effect on the quality of care. Findings of available studies also document better quality of care in teaching hospitals.

Anticipated Implementation Challenges: None known

Recommendation 4: Increase the supply and improve the stability of the Long-term Care (LTC) workforce by increasing wages and benefits of direct care workers workers employed in nursing facilities, LTC waiver programs and in-home care, as compared to counterparts working hospitals, ability to do some targeted career advancement

Sector: Make Critical Investments in the Long-term Care Workforce

Explanation: This is a multi-pronged proposal that addresses recruitment, retention and training challenges for senior care providers by providing the following (1) a general wage increase for Registered Nurses (RN), Licensed Practical Nurses (LPN), and Nursing Assistants (NAR) to create wage parity with their hospital counterparts; (2) a targeted wage increase for employees that complete the Health Support Specialist (HSS) Registered Apprenticeship program; (3) enhancement of the Nursing Facility Scholarship Program (NF-SP) and restoration of the Home and Community-based Services Scholarship Program (HCBS-SP).

The goals of this proposal are to (1) reduce the wage gap that exists between hospitals and senior care settings, making it less difficult to recruit and retain health care workers to a career in senior care and (2) support increased training and professionalism of those that enter a career in senior care.

This proposal addresses wages only, rather than wages and benefits because of uncertainty at this time about the effects that the Affordable Care Act will have on LTC providers. For example, LTC employers with 50 or fewer employees, and their employees, will be eligible to participate in any health insurance exchange. Currently, health insurance benefits for this sector of the health care workforce are not widely available or are so expensive, relative to wages, that they are not accessible. However, it is not clear at this time how this issue should be addressed and funded.

A component of this proposal references the Health Support Specialist (HSS) Registered Apprenticeship Program - a strategy to help providers meet the increasing demands for highly-skilled frontline caregivers in older adult services and help close the wage gap between older adult services and other health care sectors. HSS represents a fundamental change in the training of frontline caregivers and a shift towards a higher quality person-directed care delivery model. This career training and care delivery model can be utilized in all skilled care centers, senior housing/assisted living and home care programs.

The HSS Model: Using an innovative online classroom experience paired with on-the-job apprenticeship design, Minnesota's provider organizations would be able to move from offering traditional compartmentalized job duties (NAR, Activity Aid, Cook/Dietary Aid, Housekeeper, etc.) into a new cross-trained blended role (HSS) able to serve seniors holistically, in the emerging household model of care delivery.

- HSS is seven course, nine credit, 145 hour college certificate delivered via an online platform through four partnering MnSCU colleges and universally accessible across Minnesota.
- In addition to the classroom experience, HSS requires 2,500 hours of on-the-job apprenticeship experience overseen by the Minnesota Department of Labor Registered Apprenticeship Unit.
- Courses include: 1) Introduction to Health Support Specialist, 2) Meaningful Activities, 3) Memory Care, 4) Culinary Care, 5) Physiological Care, 6) Psychosocial, and 7) Environmental Services and related on-the-job learning experiences.
- Candidates for the program must be 18 years of age, have a high school diploma or GED and be a NAR.
- Tuition expenses for HSS are paid by the provider organization for the employee/student. Employees are also paid their hourly wage while they are completing their on-the-job hours.

Recommendations:

- A three-year phase-in of rate and wage increases, beginning October 1, 2013, using a target wage level based on 85% of hospital wage levels for RNs, 100% for LPNs, 80% for NARs and 100% of the hospital NAR wage level for HSSs, with wage increases in the first year that move employee average compensation one-third of the way from current levels to target wage levels.
  - A study of the relative value of direct care positions in hospitals and NFs to be completed by March 31, 2014 – an evaluation of samples of hospital, NF and home care related job descriptions rating them using well established methodologies to assign fair and reasonable relative wage levels,
  - Target wage levels in years two and three of the phase-in, based on the relative value study,
  - Target wage levels be determined based on Metropolitan Statistical Areas (MSAs), or similar method of regional adjustment,
  - Workers be held harmless where this recommendation would result in wage reductions for them,
  - For NFs, rate adjustments are provided based on an application process similar to what was used in 2008,
  - For waiver and in-home care providers use the "Letter of Assurance" methodology that was used in 2008, in combination with the Waiver rate setting methodology,
  - Changes in wage levels in hospitals that occur should be reflected in LTC provider wage levels, subject to the application or assurance process.
- The NF-SP should be enhanced and the HCBS-SP should be restored.

Statement of Problem Addressed by Recommendation; Rationale and Data to Explain Recommendation is a Priority: There are three primary objectives addressed by this recommendation: competitive wages, better retention of employees in the senior care field, and better training to meet the projected demographic demands. Employees in the long term care sector must be better compensated and better trained to meet the future care needs of our seniors.

Consider the following:

- **Demographics will require a prepared senior care workforce.** There is a demographic imperative in ensuring the senior living field is able to recruit and retain an adequate frontline workforce to meet the estimated 150% increase of Minnesotans over age 85 in the next 30 years. There are currently 111, 000 direct care workers, including 17,000 CNAs and 5,500 LPNs. National research projects a 48% increase in all Direct Care Worker occupations, making it the **largest occupations group in the United States by 2020** - including a 71% growth in Personal Care Attendants, 69% growth in Home Health Aides, and 20% growth in NARs.
- In Minnesota, demand for primary caregivers – NARs and Home Health Aides – is projected to grow by 65% from 2010 and 2030 in both homecare and nursing facilities (NFs).
- Currently, some NFs and other senior care providers report needing to restrict admissions due to staff shortages. This issue will worsen if the workforce challenges for the senior care sector are not addressed.
- **Recruitment to the senior care field is difficult.** Even in our current economic climate, with relatively high unemployment rates, today in Minnesota we have 214 RN, 249 LPN and 925 NAR positions that cannot be filled.
- **Senior care providers struggle with retention of staff.** Direct care workers in NFs have a current retention rate of 73.75%, ranging from 27.9% to 97.6%. Between 2003 and 2008 the average direct care retention rate stayed between 71.7% and 72.2%, and then rose a slightly with the economic downturn.
- **New models of care will be needed to address demographic demands.** There will likely be insufficient workers to continue the model of compartmentalized workers that most providers use today. Providers will look to move to a team-based, person-directed approach that will required a new approach to training and development of staff.

- **Wages for Senior Care Workers are Insufficient.** The Minnesota wage gap for caregivers working in the field of senior living is a significant factor in a competitive employment marketplace. It will be impossible to recruit and retain sufficient staff to meet increased demographic demands without enabling providers to provide more competitive wages. Direct care workers in LTC are paid substantially less than their peers who work in hospitals:

	Hospital	NF	WAGE INCREASE NEEDED TO ACHIEVE EQUAL PAY LEVELS
RN	$41.97	$26.87	56%
LPN	$20.79	$19.65	6%
CNA	$17.16	$13.00	32%

- **The state plays an important role in enabling providers to pay competitive wages.** As a result of the MA rate freeze over the last four years, NFs are not able to improve caregiver wages without substantial support from state funding. On the home and community based side, waiver rates have been cut in the last several years, and those providers as a result are also unable to address the issue of inadequate wages.
- **Challenges to Implementing HSS:** HSS represents strategy that will help providers meet the demand for highly-skilled caregivers. Currently, it is difficult to secure participation by employers due to a lack of financial resources. A key to the success of the new HSS career will be a salary schedule. To become an eligible HSS Program Sponsor, senior living communities are required to sign *Standards of Apprenticeship* with the Minnesota Department of Labor that include an outline of employee wages – making the provider report their starting caregiver salary and a wage increase for the completed HSS Journey Worker. Without a clear picture of future funding, providers cannot promise an investment in their future caregiving wages
- Low wage levels fail to acknowledge the importance and difficulty of the work done by direct care workers.

Who would implement the recommended strategy:

- The MN Department of Human Services would have a role in implementing increased wages for caregivers.
- The Minnesota Department of Labor would help oversee implementation/standards for Health Support Specialist.
- Senior care providers would partner with the state to implement Health Support Specialist program in their settings.

Implementation Resources Needed:

- **Legislation** would be required to:
  - Implement the payment adjustments for providers and general wage increases for direct care workers;
  - Authorize reimbursement for HSS-enhanced wages
  - Reauthorize the HCBS-SP;
  - Expand the NF-SP course of study eligibility.
- **Funding** would need to be appropriated as follows:
  - <u>For General Wage Increase:</u> We estimate that a 1% wage increase for all LTC direct care workers would have an annual state cost of $10.3 million. The annual state share cost of fully closing the gap would be about $320 million. The cost of the first year of a three year phase-in, with an October 1 effective date, at the recommended levels of parity, would be about $28 million, (second year is estimated to cost $78.5 million, third year $118.5 million and fourth year $127.5 million).

- For NF-SP and HCBS-SP: The NF-SP program will need an additional $75,000 per year, state share, and the HCBS-SP program will require an appropriation of $500,000 per year, state share.
- For conducting the Relative Value Study: $100,000

- **Administrative action** to implement would be different between NFs and the waiver and in-home care programs, though in both areas methods that have been used previously would be suitable. For NFs, the rate increases would be implemented upon completion of a timely application and approval process that would ensure that the funds made available are, in fact, used to cover the costs of the wage increases and associated costs such as FICA. For waiver and in-home care providers, the increase would be incorporated into the waiver rate setting methodology and implemented using a "Letter of Assurance" methodology.

Intended Outcomes, if implemented: (on health care, health status, access and/or cost, including return on investment, if available) More competitive wage levels will enable providers to be more competitive in the overall labor market, contributing to a higher quality and more stable LTC workforce, which will, in turn, contribute to improved quality and greater efficiency of services. In addition, with the aging of Minnesota's population, it is essential to move forward with strategies that will support the needed growth in the LTC workforce.

Anticipated Implementation Challenges: Given the history of NF rebasing, with a back-end loaded, eight year phase-in that ultimately was cancelled, it will be costly but also advisable to phase-in increases with straight-line or front-end loaded investments.

Recommendation 5: Increase access to care in Greater Minnesota by supporting and expanding telehealth and related technology to improve quality and access and extend workforce capacity. Specifically, 1)broaden providers eligible for Medicaid telehealth reimbursement, 2) allow the nursing home 60 day required visit to be a telehealth visit, 3) develop demonstration projects and training for emerging telehealth models, and 4) support the efforts of the Governor's Task Force on Broadband to close bandwidth gaps in rural MN

Sector: Extend workforce capacity through Telehealth and related technology

Explanation: Workforce shortages exist in all of the core mental health professions and many medical disciplines in rural Minnesota. Lack of access to these professionals is a driving force for the use of telehealth. Telehealth technology helps to combat this shortage. The use of teleconferencing is also effective in heightening collaboration among health care professionals. Telehealth services can bridge the health services gap for patients with limited access to mental health and other specialty services, in particular those in rural and frontier communities. Improved access, quality and cost demonstrate that telehealth is a timely and effective method these health needs in rural areas.

Statement of Problem Addressed by Recommendation; Rationale and Data to Explain why Recommendation is a Priority:

Telehealth has proven potential to extend the reach of health professional services, including mental health and substance abuse treatment services, and improve acute and chronic disease outcomes. However, regulatory, reimbursement and infrastructure barriers limit the potential of telehealth to meet these goals in Minnesota. Limited reimbursement, inconsistent reimbursement policies, infrastructure challenges, and credentialing concerns create significant barriers to expanding the use of telehealth. An additional barrier in some areas is the availability of a broadband connection and appropriate bandwidth. There is also a need to and broaden acceptance of telemedicine in emergency departments (especially in rural communities) and as a tool for consultations involving psychiatric and addiction and substance use disorders.

Telehealth in Minnesota: At a Crossroads Karen Welle & Stuart Speedie, Rural Minnesota Journal, 2:1, 2007. Center for Rural Policy and Development

Regional Medicaid Reimbursement For Telehealth/Telemedicine Services Great Plains Telehealth Resource Center, University of Minnesota 2011

Who would implement the strategy:

Broaden providers eligible for Medicaid telehealth reimbursement – DHS

Develop telehealth demonstration projects and training resources – Initiated by MDH.

Broadband development and policy: Governor's Broadband Task Force

Implementation Resources Needed:

Legislation and/or administrative action needed to revise Medicaid reimbursement and requirements. It is hard to predict whether forecast costs would be positive or negative.

Legislation may be sought by the Governor's Broadband Task Force to implement its recommendations.

Funds will be needed to develop telehealth demonstration projects and training resources. Sources could be state, federal or private.

Intended Outcomes, if implemented (on health care, health status, access and/or cost, including return on investment, if available):

Increased access to specialty and mental health services. All mental health procedures that are delivered in person can be delivered remotely via telehealth, as can many medical specialty services.

Earlier diagnosis and treatment will yield better outcomes. Earlier intervention and easier access helps patients engage in their care and, ultimately, this will improve mental health outcomes and save health care costs.

Cost-effective delivery of services. More than 85 percent of patients seen via telemedicine remain in their local communities, resulting in lower costs of care and further enhancing the financial viability of the community hospital or clinic. Other potential cost savings come from reduced wait times and a reduction of no-show rates. Costs are reduced overall for patients, providers and health systems, even after including start-up costs for the necessary equipment and technology infrastructure.

Enhanced coordination of care. As the integration of primary care and mental health continues, more psychiatrists are providing peer consultation to family practice physicians, especially in rural Minnesota. Research shows that patients most often discuss their mental health concerns first with their primary care physician. Telemental health also creates an opportunity to engage additional mental health providers.
Anticipated Implementation Challenges: No major challenges foreseen

Recommendation 6: Improve access to dental care by supporting start-up changes and practice redesign for dental therapists and advanced dental therapists; and support all state-level administrative actions to enable dental hygienists with a collaborative agreement with a dentist to perform oral examinations as part of child and teen checkups.

Sector: Investments in the Oral Health Workforce

Background: Dental therapists (DTs) and advanced dental therapists (ADTs) are new midlevel dental providers, and Minnesota became the first state to license these providers in 2009. DTs/ADTs work under the supervision of a Minnesota-licensed dentist through a collaborative management agreement; practice in settings that serve low-income, uninsured, and underserved patients or are located in dental health professional shortage areas; and provide oral health care services, including preventive, evaluation and assessment, palliative, therapeutic, and restorative services. As of April 2012, there are twelve licensed DTs, who comprised the initial 2011 graduating cohort. The second class, of about the same size, graduates in 2012

Statement of Problem Addressed by Recommendation: Only 58% of the uninsured in Minnesota had a dental visit in 2012, compared with 80% of those with insurance. Dental therapists and advanced dental therapists, who are required by statute to serve the underserved population, have the potential to improve dental access for uninsured and public program patients. However, dental employers have been slow to hire and integrate these providers as members of their staff because it requires rethinking and redesigning the roles of dental providers such as dentists, hygienists and dental assistants. Anecdotal reports also suggest that many dentists do not know how to make this delivery model financially sustainable. Other barriers to integrating DTs/ADTs into the current dental clinic model include accommodations for operatory space and equipment, schedule coordination with other dental staff, and integration of the DT/ADT into the work flow process. In addition, many supervising dentists have limited experience with collaborative management agreements, and need information pertinent to the cost-effectiveness or potential benefits of adding a DT/ADT to the dental staff.

Rationale and Data to Explain why Recommendation is a Priority: DTs/ADTs are trained and charged to meet the oral health needs of the uninsured and underserved. To achieve this, practice barriers will need to be mitigated to fully leverage the potential DTs/ADTs have to offer, and to realize a return on investment made in this provider type.

Implementation Resources Needed: A multi-pronged approach is needed to support the entry and integration of DTs/ADTs into existing oral health care teams. [2]

1. Provide state funding to develop model practice types, template Collaborative Management Agreements (CMAs) and liability coverage terms for DTs/ADTs and to increase awareness among the existing oral health providers and the public about the new profession (Approximately $500,000, one-time)
2. Provide state grants to support start-up costs of dental therapist employers. (Approximately 30 grants @ $50,000 = $1.5 million)

Intended Outcomes, if implemented (on health care, health status, access and/or cost, including return on investment, if available): The addition of this new provider will expand the reach and capacity of oral health care practitioners to meet oral health care needs of the underserved and uninsured. Approximately 20 new graduates will be available each year, and if fully employed, this workforce will be able to serve an additional 25,000 to 40,000 patients each year who might not otherwise receive care. Improved access to dental care will prevent more complex dental issues for individuals, and therefore, prevent potential emergency room visits due to non-traumatic dental emergencies. Improved oral health impacts many common physical health

conditions such as diabetes. The reduction in emergency room visits due to dental emergencies will result in a reduction in costs to the public health system.

Anticipated Implementation Challenges: These efforts require coordination among multiple entities. Modifications to existing practices and changes in traditional provider roles will likely be controversial in the beginning. However, model practices that demonstrate financial feasibility with the inclusion of the DT/ADT will counter such controversies.

Additional Oral Health Issue: Authority for dental hygienists to conduct and be reimbursed for oral examinations provided as part of Child and Teen Check-ups.

The Workforce Work Group believes clarification of federal EPSDT requirements regarding the ability for collaborative agreement dental hygienists to fulfill the EPSDT requirements for a dental exam as part of Child and Teen Check-ups could have significant impact on children's oral health. On June 13, staff learned that "CMS has decided that, according to existing federal policy, the services provided by collaborative practice dental hygienists in Head Start classrooms meet the EPSDT requirement for a dental exam according to a State's EPSDT dental periodicity schedule," and the Minnesota Department of Human Services is the lead agency responsible to enact this change. The Work Group supports any administrative steps necessary for DHS to permit dental hygienists to perform oral examinations as part of Child and Teen Check-ups and secure appropriate reimbursements. This will improve access to oral health examinations, especially in rural areas. Poor oral health affects school attendance, speech, nutrition, growth and function, social development, and quality of life. Children with dental-related problems are estimated to miss more than 51 million hours of school each year, and recent research also points to an association between poor oral health and poor school performance. [3]

Recommendation 7. Restore and increase the state's Health Professional Loan Forgiveness Program beyond its pre-cut 2011 budget by adding 100 new participants annually for four years. Add psychologists, social workers, Licensed Alcohol and Drug Counselors, dental therapists and advanced dental therapists, dental hygienists, occupation therapists and physical therapists as eligible participants.

Sector: Transform Primary Care

Statement of Problem Addressed by Recommendation, Rationale and Data to Explain why Recommendation is a Priority:
Driven by by the aging population, provider retirements and care newly requested by those gaining coverage through the Affordable Care Act, Minnesota's rural and underserved areas will need approximately 400 additional primary care providers by 2020. These needs will be in addition to the current shortage of 200 primary care providers in these areas. In addition to producing adequate numbers of new health professionals, including those from diverse racial and ethnic backgrounds, influencing where those providers choose to work is key to achieving Minnesota's health reform and workforce goals. Loan forgiveness is a proven strategy to induce health professionals to practice where they're most needed. Research also confirms that providers who are incented to practice in underserved areas stay there, making a long term contribution in response to a relatively modest upfront investment in loan forgiveness. The state's loan forgiveness program does not have sufficient funds to respond to these needs, especially following a budget reduction in 2011. The program can fund fewer than 30% of the applications received. In addition, several professions important to transforming care delivery are not included in the program.

Current occupations included in the program are physicians who agree to practice in rural and underserved areas, advanced practice nurses, physician assistants and pharmacists who agree to serve in rural areas, dentists who agree to serve significant numbers of public program and sliding fee patients , registered nurses who agree to work in nursing homes and nursing/allied health faculty. Funds are allocated proportionally among the eligible professions according to the vacancy rate for each profession in the required geographic area, facility type, teaching area, patient group, or specialty type. Applicants are selected based on their suitability for practice serving the required geographic area or facility type. For each year that a participant meets the service obligation, up to a maximum of four years, they receive a payment equivalent to 15 percent of the average educational debt for indebted graduates in their profession.

Bringing Health Care to the Heartland: An Evaluation of Minnesota's Loan Forgiveness Programs for Select Health Care Occupations MDH April 2007

An Evaluation of Minnesota's Loan Forgiveness Programs for Select Health Care Occupations MDH August 1999

Outcomes of states' scholarship, loan repayment, and related programs for physicians. Pathman DE, Konrad TR, King TS, Taylor DH Jr, Koch GG Med Care. 2004 Jun;42(6):560-8

Implementation Resources Needed:
a. Legislation: Current statute would be amended to add new professions
b. Funding: Budget request (add 100 slots. Approx. $2,200,000 in year 1, rises to $8,200,000 in year 4.)

	Year 1	Year 2	Year 3	Year 4	
Year 1 – Add 100 @ $20,000	**$2,0000,000**	**$2,0000,000**	**$2,0000,000**	**$2,0000,000**	
Year 2– Add 100 @ $20,000		**$2,0000,000**	**$2,0000,000**	**$2,0000,000**	**$2,0000,000**
Year 3– Add 100 @ $20,000			**$2,0000,000**	**$2,0000,000**	**$2,0000,000**
Year 4– Add 100 @ $20,000				**$2,0000,000**	**$2,0000,000**
Year 5					**$2,000,000**
Administration	**$200,000**	**$200,000**	**$200,000**	**$200,000**	**$200,000**
Total	**$2,200,000**	**$4,200,000**	**$6,200,000**	**$8,200,000**	**$8,200,000**

Who would implement the recommended strategy? MDH

Intended Outcomes, if implemented (on health care, health status, access and/or cost, including return on investment, if available): Access outcomes will be improved provider availability in underserved communities. As a strategy that affects provider distribution at the end of training, outcomes occur relatively quickly, and the cost of loan forgiveness incentives is less than that of the preceding educational investment.

Anticipated challenges with implementation? None

Recommendation 8: Increase the supply of long term care workers by expanding the Minnesota FastTRAC (Training, Resources, and Credentialing) Adult Career Pathway program that trains nontraditional adult learners.

Sector: Investments in the Long-term Care Workforce

Explanation: Minnesota FastTRAC is an innovative career pathways strategy that rapidly prepares educationally underprepared adults for entry level jobs in health care and other industries. Many adults seeking career-specific training also need to build their basic academic skills. FastTRAC addresses both sets of skills by teaming up Adult Basic Education and postsecondary instructors in the classroom. This allows students to learn basic skills like literacy and math in the context of their career interests, making learning more relevant. In addition, adults benefit from intensive career and academic advising, and other support services such as child care and transportation.

FastTRAC is a collaboration between MnSCU, the Minnesota Department of Education (MDE), the Department of Employment and Economic Development (DEED), local workforce development partners, human services, and community-based organizations.[4] Programs similar to FastTRAC are in place in seven other states.

Statement of Problem Addressed by Recommendation: Minnesota is facing an unprecedented age wave in the coming years, and as a result there will a high corresponding demand for caregivers working in long-term care settings, including nursing homes, housing with services, and in-home care. Minnesota is currently unprepared to meet this demand, with high vacancy rates, high turnover and difficulty recruiting for these positions.

Many adults who could be suitable for these positions need help with basic academic skills and career-specific training. Traditional educational programs assume a certain level of academic readiness, and offer these services separately and sequentially. FastTRAC integrates these trainings, offers support services and allows nontraditional learners to reskill themselves quickly in a cost-effective approach tailored to worker and employer needs.

Rationale and Data to Explain why Recommendation is a Priority: The 2008 Institute of Medicine (IOM) report on *Retooling for an Aging America: Building the Health Care Workforce* notes the need for enhancing geriatrics competence especially among certified nursing assistants (CNAs) and direct care workers (including nurse aides, home health aides, personal care aides) who are the primary care providers for older adults. The IOM report also highlights the importance of supporting training, recruitment and retention of long term care workers. Minnesota's FastTRAC Adult Career Pathway programs are designed to boost both the competence and readiness to respond to the aging population and the size/capacity of the long term care workforce.

807 adults have enrolled in FastTRAC ABE bridge courses. Of these, 540 have successfully moved into integrated MnSCU/ABE courses – a success rate of 67%.

Models similar to the Minnesota FastTRAC are underway in six other states that include llinois, Michigan, Ohio, Wisconsin, Washington, and Oregon. Similar models have been endorsed by some national organizations such as the National Governors Association, the Joyce and Lumina Foundations, the National Fund for Workforce Solutions, and the U.S. Departments of Labor and Education.5

Implementation Resources Needed: MN FastTRAC is a public private partnership and has benefitted from the planning and implementation grants from the Joyce and Bremmer Foundations. However to sustain and expand the programs offered, a dedicated funding stream is critical. This proposal seeks a sustainable funding mechanism to scale up and institutionalize the adult career pathways throughout Minnesota.

By 2013, the goals of FastTRAC program are to serve 3,000 adults; establish 50 FastTRAC adult career pathways offered at MnSCU campuses through the integrated ABE and Career Technical Education courses, and 50 FastTRAC bridge courses offered through the ABE consortia. The program also aims to place 75 percent (2,250) of the participants in employment, and ensure that at least 50 percent (1,500) of enrolled FastTRAC participants will have earned industry-recognized credentials by 2013. At this rate, by starting now and in combination with complementary strategies, FastTRAC can get Minnesota much closer to meeting future workforce skill demands.

Funds requested: $2.65 million per FY

Intended Outcomes, if implemented (on health care, health status, access and/or cost, including return on investment, if available): Increasing the number of trained direct care long term care workers will help home, community-based and institutional aging services providers minimize unnecessary institutionalization and improve quality of life for older Minnesotans who are able to remain independent or receive high quality nursing facility care when needed, avoiding unnecessary medical and long term care costs.

Anticipated Implementation Challenges: Minnesota FastTRAC requires a new way of doing business by adult educators, postsecondary institutions and the workforce development system. The FastTRAC team has carefully built buy-in in each of these sectors; however, more and on-going data collection and evaluation regarding credential attainment and securing family-supporting wage jobs by FastTRAC participants is required to ensure full success of this model. With the collaborations in place, the program hopes to deepen its collaborations, design industry-recognized credential for program graduates; funds needed to adopt similar models that offer career/technical education and training in all MN state colleges.

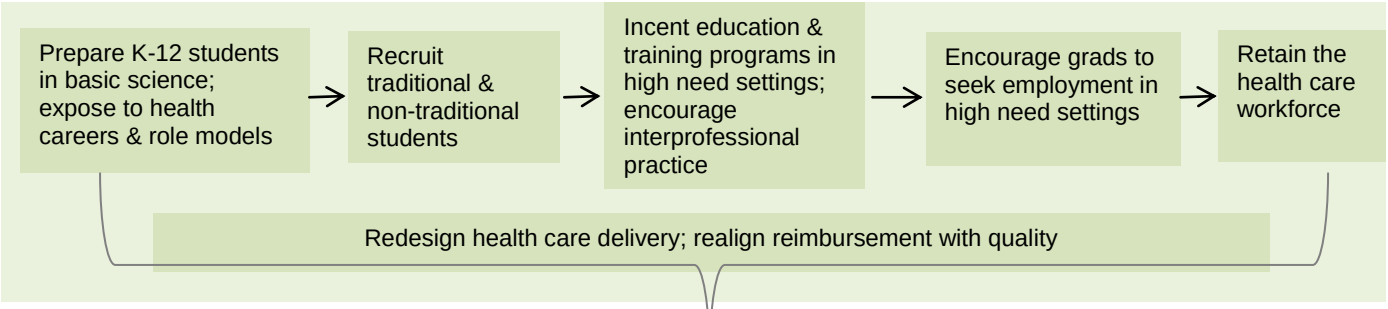
Recommendation 9: Increase diversity in the healthcare workforce by supporting a range of health professions diversity programs and helping foreign-certified physicians obtain Minnesota licensure and investing in recruiting diverse medical school candidates

Specifically, 1) initiate and fund programs that expose K-12 students to health careers and emphasize the development of science, technology, engineering and mathematics (STEM) competencies;[6] 2) support new and existing post-secondary level programs that encourage, mentor, and train underrepresented students to pursue healthcare careers;[7] expand programs (such as the Minnesota's Future Doctors program at the University of Minnesota Medical School, and the Minnesota Refugee Physician Training Pathway) that support students in medical, dental or pharmacy schools until matriculation;[8] 3) explore alternative roles/capacities for foreign trained physicians who are unable to practice as physicians in the US health care system

Sector: Investments in the healthcare workforce education pipeline

Explanation: To prepare Minnesota's future healthcare workforce, investments in the workforce "pipeline" beginning at the K-12 level through post-secondary and into the post-graduate level are critical. Programs targeting traditionally underrepresented students (nontraditional, minority, rural, low-income, foreign trained) that offer early health career awareness and ongoing support such as academic enrichment, mentorship, scholarships, and training/residency opportunities need to be expanded to build a diverse healthcare workforce that offers culturally competent care and reduces disparities in access and care outcomes.

The Workforce Development Pipeline



Often foreign trained physicians are unable to practice as physicians in the US for a variety of reasons (such as lack of medical language fluency; differences in understanding of patient-centered health care delivery model as practiced in US; foreign credentials with no US equivalents; limited computer skills, too few residency slots). Exploring alternative professional roles, credentials, and funding for foreign trained physicians that leverages their past medical training and experience, language fluency and community ties is another strategy to build a diverse and culturally competent healthcare workforce.

Statement of Problem Addressed by Recommendation: The pathway to successful healthcare careers can be lengthy and requires students to make deliberate academic choices early on. Programs that support students, provide early exposure and mentorship throughout this process can contain the "leaks" in the pipeline and expand the healthcare workforce. Communities need to "grow their own" healthcare providers who are responsive to local needs and increasing and changing demand for personalized health care. Enriching and diversifying the healthcare provider pool (both in the medical and allied health settings) can in part address healthcare disparities as findings suggest that provider biases/prejudices and uncertainty when treating ethnic and racial minorities can result in suboptimal quality and care outcomes for these populations.[9]

Who Would Implement this Recommendation: A public-private partnership between educational institutions and health care employers.

Implementation Resources Needed:

$ 2 million requested per year to start and supplement programs that provider early healthcare career awareness and support. Eligibility for grants will require a matching contribution from health care employers or other organizations.

$1.4 million is requested to support the Minnesota Refugee Physician Training Pathway program.

Explore partnerships with MnSCU to develop a FastTRAC credential for foreign trained physicians and allocate necessary resources (costs unknown as this time). In addition, build partnerships with healthcare employers that can contribute to a revolving fund to bear the residency costs for training foreign trained physicians, and will hire them post-training.

Intended Outcomes, if implemented: Increase in number and diversity of the healthcare workforce to provide culturally competent care.

Anticipated Implementation Challenges: None

Recommendation 10: Consider the impact of Minnesota joining the Interstate Nurse Licensure Compact, through establishing a stakeholder work group and conducting a study of relevant issues.
NOTE: Agreement among work group members was not reached on this recommendation.

Sector: Transform Primary Care

Explanation: The Nurse Licensure Compact (NLC) is an agreement between states to mutually recognize the license of a nurse as authority to practice in other states that are party to the agreement. The basic concept of the mutual recognition model of nurse licensure is to issue a nurse one license by state of residence, and allow the nurse to practice in other states subject to each state's practice regulations.

Statement of Problem Addressed by Recommendation: An impact evaluation of the NLC is needed to inform Minnesota policymakers. The scope of the evaluation may include impact of the NLC on access to care, quality and patient safety; numbers of nurses expected to arrive in or leave Minnesota and net effects, to the extent this can be determined; effects on collective bargaining and labor relations; effects on regulation, discipline and the Board of Nursing; effects on employers and health systems; and issues related to telehealth and interstate practice.

Rationale and Data to Explain why Recommendation is a Priority: Nursing is by far the largest sector of Minnesota's licensed health care workforce, and nurses play critical roles in all health care settings. Nurses' roles are also central to a reformed health care system. Understanding the licensing, supply/demand, working conditions and other issues possibly related to implementation of the Nurse Licensure Compact is important to workforce and health reform planning.

Implementation Resources Needed: Funding ($120,000) is needed for a study and stakeholder workgroup process.

Intended Outcomes, if implemented (on health care, health status, access and/or cost, including return on investment, if available): To be identified by study and workgroup.

Anticipated Implementation Challenges: None, once consensus reached on study scope.

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ENDNOTES

[1] Further discussion on the definition of 'primary care' medicine may be fruitful. The traditional definition of primary care medicine includes family medicine, general internal medicine and pediatrics, and sometimes obstetrics. The work group also discussed the centrality of general surgery.

[2] Inclusion of dental therapists and advanced dental therapists in the state's loan forgiveness program is part of recommendation 4.

[3] Children and Oral Health: Assessing Needs, Coverage, and Access. Kaiser Commission Policy Brief, June 2012, Available at www.kff.org/kcmu

[4] FasTRAC programs that train the long term care workforce include Southwest Minnesota Universal Health Care Worker (trains certified nursing assistants, certified home health aides and trained medication administration workers); Rochester Community & Technical College Mayo C.N.A. FastTRAC Program (trains certified nursing assistant, hospital certified nursing assistant); Anoka Healthcare/Nursing Pathways (trains universal health care worker in older adult services certificate).

[5] http://www.shifting-gears.org/images/PDF/ProjectResources2/shiftinggearsstateinnovationstoadvanceworkersandtheeconomyinthemidwest0710.pdf

[6] For example, the Scrubs Camp which is a partnership of the MnSCU and healthcare employers exposes middle- to- high school students to healthcare careers

[7] For example, the Center for American Indian and Minority Health at the University of Minnesota Duluth through its programs—the Stepping Stones to Health Careers; the Native Americans into Medicine (NAM); and the Pre-Admission Workshop—supports the exploration and preparation for health careers for promising American Indian students in high school all the way to preparing students for medical school exams.

[8] For example, the Minnesota's Future Doctors program at the University of Minnesota Medical School targets and supports low-income, rural and minority college students through medical school matriculation. The annual budget for Minnesota's Future Doctors program is **$375,000**. The program supports 50 college freshmen at the cost of $6,500 per scholar. Historically the program has been funded by medical school Dean's office, a private donor, and the private foundation. However this level of funding is no longer sustainable. Another such program is the Minnesota Refugee Physician Training Pathway, a collaboration between the University of Minnesota and the HealthEast care system, selects, updates and trains refugee physician skills so they can compete for residency slots in family medicine programs. The expectation is that after residency, they will practice in communities of need. Three Somali physicians are starting their 2nd year of residency in Family Medicine. Three refugee physicians completed the preparation program; one has begun a family medicine residency, two will participate in the match for 2012-13. Applications for the preparatory program open in Sept, 2012 and the 7-month program begins in December, 2012.

[9] Institute of Medicine. March 2002. What Healthcare Consumers Need to Know About Racial and Ethnic Disparities in Healthcare. Available at: http://www.iom.edu/~/media/Files/Report%20Files/2003/Unequal-Treatment-Confronting-Racial-and-Ethnic-Disparities-in-Health-Care/PatientversionFINAL.pdf